ST. ANASTASIA SCHOOL

A PHYSICAL EXAMINATION IS REQUIRED for Original Entry, Kindergarten and 6th grades

Form (Grade): _____ Date of Exam: _____

Name of Child: _____ Date of Birth: ____/____/_____ Sex: M___ F___

Address: _____ City: _____ State: _____ Zip: _____

IMMUNIZATION STATUS

Vaccine (Doses)	Enter month, day & year (please give exact dates) each immunization was given				
Diphtheria-Tetanus-Pertussis (DTaP)	1	2	3	4	5
Tetanus-Diphtheria-acellular Pertussis (Tdap)	1				
Polio 4 required	1	2	3	4	
Measles-Mumps-Rubella (MMR)	1	2			
Hepatitis B	1	2	3	Hep A (1)	Hep A (2)
Meningococcal/MCV	1	2	HPV 1	HPV 2	HPV 3
Varicella (2 required or hx Dis)	1	2	Chicken Pox Disease Date:		
TB Risk Assessment ___Negative / ___Positive** **If positive – Result of PPD required BCG: Date INH Therapy:					
Tuberculin Testing Type: Date: Result: neg.( ) pos. ( )					

HEALTH HISTORY (Give Dates, if known)

Allergy _____ **Seizure Disorder _____**

Asthma _____ **Diabetes _____**

Drug Allergy _____ **Heart Disease _____**

Give significant details of child's medical history, including serious illness, operations, accidents, etc.

_____

Report of Examination: Height: _____ Weight: _____ BMI: _____ BMI %:_____ B/P: _____ Pulse: _____

	Normal	Abnormal
Emotional Status	( )	( )
General Nutrition	( )	( )
Skin	( )	( )
Eyes	( )	( )
Glasses:____ Contacts: ____ R: ___ L: ___		
Ears	( )	( )
Hearing	( )	( )
Nose & Throat	( )	( )

	Normal	Abnormal
Teeth	( )	( )
Glands	( )	( )
Heart	( )	( )
Lungs	( )	( )
Abdomen	( )	( )
Genitalia (Male)	( )	( )
Neuro-muscular	( )	( )
Speech	( )	( )

	Normal	Abnormal
Skeleton	( )	( )
Posture	( )	( )
Scoliosis (bending position)	( )	( )

Is student being observed or treated for scoliosis?
Yes ___ No ___

Is child under treatment? Yes ___ No ___ should this child have restrictions on play, PE or sports activities? Yes ___ No ___

Medical Diagnosis/Restrictions: _____

Medications prescribed: _____

Life threatening health concerns will be shared with teachers unless instructed otherwise.

Print name of Physician _____ **Signature of Physician** _____

Telephone: _____ **Address:** _____